

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055167	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2026
NAME OF PROVIDER OR SUPPLIER Vernon Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1037 W. Vernon Avenue Los Angeles, CA 90037	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review the facility failed to ensure:1. One expired large can of cherry fruit filling, in the dry storage room was disposed. 2. Four cereal bowls on the shelf in dry storage were not dated.3. The refrigerator (reach in) had containers of applesauce, juice, and jelly without use by date (the last day a manufacturer recommends consuming a product for peak quality and safety).4. The Dietary Aide (DA) 1 had touched the cleaned dishes after touching dirty dishes without removing gloves and washing her hands. These deficient practices had the potential to result in harmful bacteria growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to food borne illness in 87 out of 93 residents who received food from the kitchen. During a concurrent observation and interview on 1/6/2026 at 8:40 a.m., with Dietary Services Supervisor (DSS), in the dry storage room, there was one large can of expired cherry fruit filling and four bowls of dry cereal without a used by date was reviewed. The DSS stated that the can of cherry fruit filling was expired should have been disposed. The DDS stated the bowls of cereal did not have a used by date. The DSS stated these items should have been thrown away so it's not used again. The DSS stated had the potential to make the residents sick. During a concurrent observation and interview on 1/6/2026 at 8:45 a.m., with the DSS, at the refrigerator (reach in), there were containers of applesauce, juice, and jelly without use by date. The DSS stated the items did not have a used by date. The DSS stated the purpose of utilizing the use by date, so the staff knows when to toss the items to prevent illnesses to residents. During a concurrent observation and interview on 1/6/2026 at 9:00 a.m., with the DSS, the Dietary Aide (DA) 1 did not remove gloves nor washed her hands after touching dirty dishes and went to touch clean dishes with the same gloves. The DSS stated one staff member is responsible for washing the dirty dishes and another dietary aide was responsible for the clean dishes. The DSS stated DA 1 was to remove her gloves and wash her hands after touching the dirty dishes. The DSS stated this would prevent cross-contamination and not spread to the residents. During a review of the facility's policy and procedures (P&P) titled, Food Storage and Handling, dated 6/2024, the P&P indicated dry storage area place opened products in storage containers that are labelled and dated. The P&P indicated canned fruit storage use within 12 months. During a review of the facility's policy and procedures (P&P) titled, Dietary Department- Infection Control, dated 6/2024, the P&P indicated proper hand washing after handling soiled equipment or utensils and immediately before engaging with clean equipment and utensils.		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure one of six sampled residents (Resident 82) Certified Nursing Assistant (CNA) 1 was seated while feeding Resident 82. This deficient practice of CNA 1 not seated while feeding Resident 82 had the potential to cause him to feel uncomfortable. During a review of Resident 82's admission Record ([Face Sheet] front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 4 was initially admitted to the facility on [DATE] and was readmitted on [DATE]. Resident 82's diagnoses dysphagia (difficulty swallowing), hemiplegia (paralysis of the arm, leg, and trunk on the same side of the body), and aphasia (a disorder that makes it difficult to speak). During a review of Resident 82's Minimum Data Set ([MDS] a resident assessment tool), dated 10/24/2025, the MDS indicated Resident 82's cognition (ability to learn, reason, remember, understand, and make decisions) was severely impaired. The MDS indicated Resident 82 was dependent (helper does all the effort) on staff for eating, showering, and dressing. During a review of Resident 82's physician orders titled, Order Summary Report, dated 12/10/2025, the physician orders indicated Resident 82 was incapable of making healthcare decisions. During a review of Resident 82's physician orders titled, Order Summary Report, dated 12/18/2025, the physician orders indicated a controlled carbohydrate diet for Resident 82. During an observation on 1/6/2026 at 12:49 p.m., CNA 1 was feeding Resident 82 while standing. During a concurrent observation and interview on 1/6/2026 at 12:52 p.m., with CNA 1, in Resident 82's room, CNA 1 was feeding standing and leaning over Resident 82 while feeding him. CNA 1 stated the process was to sit with Resident 82 during feedings. CNA 1 stated the reason for sitting with Resident 82 was to make him feel more comfortable while he was eating. During an interview on 1/7/2026 at 3:08 p.m., with Licensed Vocational Nurse (LVN) 3, LVN 3 stated when feeding the residents the Certified Nursing Assistants were to sit with the resident during feeding so the resident would feel dignified while eating. LVN 3 stated Resident 82 would feel more relaxed, not feel intimidated (behaviors that create fear compromises patient safety and well-being), and feel rushed to eat. During a review of facility's policy and procedures (P&P) titled, Restorative Dining Program, dated 1/2012, the P&P indicated the facility was to provide the opportunity for the residents to attain their highest level of independence in feeding. The P&P indicated feeding techniques the staff member should sit while assisting or feeding resident. During a review a facility's P&P titled, Residents Rights-Accommodation of Needs, dated 1/2012, the P&P indicated the facility's environment is designed to assist the resident and maintaining the resident's dignity and well-being		

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to: 1.Ensure beneficiary notices were accurately completed for two of two sampled residents (Resident 21 and Resident 109). This deficient practice had the potential to result in residents and/or their responsible parties not being notified of their payment options (Option 1-Resident will pay but can appeal insurance, Option 2- Resident will pay and cannot appeal insurance, Option 3- Resident no longer wants care or services provided) after Medicare Part A benefits expired. Findings:a. During a review of Resident 21's face sheet (front page of the chart that contains a summary of basic information about the resident), the face sheet indicated Resident 21 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), type 2 diabetes (a disorder characterized by difficulty in blood sugar control and poor wound healing), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and anxiety (a feeling of unease, worry, or fear about future events).During a review of Resident 21's Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN- a mandatory notice from a Skilled Nursing Facility to a Medicare patient, informing them that certain skilled services such as therapy and nursing services may not be covered by Medicare and that the patient could become financially responsible, allowing the patient to choose whether to continue the non-covered care) form, dated [DATE], the SNF ABN form indicated Resident 21's last day for Medicare Part A Skilled Services coverage was [DATE]. Resident 21's SNF ABN indicated, as of [DATE], Resident 21 would have to pay \$376.00 per day out of pocket expenses for continuation of care services provided by the facility. The SNF ABN form did not indicate which one of the three service options Resident 21 chose. During a review of Resident 21's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated [DATE], the MDS indicated Resident 21's cognitive skills were cognitively intact. The MDS also indicated Resident 21 required supervision with activities of daily living (ADLs-routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 21's history and physical (H&P) form, dated [DATE], the H&P indicated Resident 21 did not have the capacity to make medical decisions but had the capacity to make needs known. b. During a review of Resident 109's face sheet, the face sheet indicated Resident 109 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included encephalopathy (a disease in which the functioning of the brain is affected by an infection or toxins in the blood), chronic obstructive pulmonary disease (COPD- chronic lung disease causing difficulty in breathing), bipolar disorder, and depression (a serious, common mood disorder causing persistent sadness and loss of interest).During a review of Resident 109's H&P form, dated [DATE], the H&P indicated Resident 109 had fluctuating capacity to understand and make decisions.During a review of Resident 109's MDS, dated [DATE], the MDS indicated Resident 109's cognitive skills were cognitively intact. The MDS also indicated Resident 109 required substantial assistance with ADLs.During a review of Resident 109's SNF ABN form, dated [DATE], the SNF ABN form indicated Resident 109's last day for Medicare Part A Skilled Services coverage was [DATE]. Resident 109's SNF ABN indicated as of [DATE], Resident 109 would have to pay \$376.00 per day out of pocket expenses for continuation of care services provided by the facility. The SNF ABN form did not indicate which one of the three service options Resident 109 chose. During a review of Resident 109's face sheet, the face sheet indicated Resident 109 was discharged on [DATE]. During a concurrent interview and record review, on [DATE] at 1:40 p.m., with the Business Office Manager (BOA 1), BOA 1 stated the protocol for beneficiary notices was to issue the SNF ABN to the residents 3 days prior to their last Medicare Part A coverage day. BOA 1 stated the Business Office would explain the form and three options to the residents so the residents would be able to make an (continued on next page)		

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	informed decision about their care. BOA 1 stated SNF ABN options were explained to Resident 21 and Resident 109, but the service options weren't checked. BOA 1 stated Resident 21 and Resident 109 should have had checked one of the 3 options. BOA 1 stated the risk of not accurately completing a SNF ABN form would appear as if the beneficiary process was not explained to the resident. During a review of the facility's policy and procedures (P&P), titled Beneficiary Notice Initiative, dated [DATE], the P&P indicated the purpose of the beneficiary notice was to determine and inform Medicare beneficiaries of coverage decisions in accordance with Medicare guidelines for Medicare Part A and Part B coverage.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to:1.Ensure a Complete Blood Count (CBC- a routine blood test that measures and evaluates your red blood cells, white blood cells, and platelets) and Comprehensive Metabolic Panel (CMP- a blood test checking organ function and chemical balance) labs were obtained for one of six sampled residents (Resident 4).This deficient practice had the potential to result in fluid and electrolyte imbalances.Findings:During a review of Resident 4's face sheet (front page of the chart that contains a summary of basic information about the resident), the face sheet indicated Resident 4 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Resident 4's diagnoses included a encephalopathy (a disease in which the functioning of the brain is affected by an infection or toxins in the blood), dysphagia (difficulty swallowing), chronic kidney disease (a disease characterized by progressive damage and loss of function in the kidneys) and vitamin B-12 anemia (a condition where the body can't make enough healthy red blood cells because it lacks vitamin B12).During a review of Resident 4's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 10/23/2025, the MDS indicated Resident 4's cognitive (thinking) skills were severely impaired. The MDS also indicated Resident 4 was dependent on staff with Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).During a record review of Resident 4's physician's orders, dated 11/21/2025, the physician's order indicated CBC and CMP.During a review of Resident 4's history and physical (H&P), dated 1/4/2026, the H&P indicated Resident 4 did not have the capacity to make decisions.During a record review of Resident 4's lab results, on 1/7/2026, Resident 4's CBC and CMP lab results couldn't be located in her medical chart or the facility's laboratory services binder.During a concurrent interview and record review, on 01/07/2026 at 2:43 p.m., with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated the protocol for physician orders are to be noted and carried out for all residents. LVN 1 stated the protocol for lab work order required a licensed nurse to notify the facility's lab company of a resident's new lab order. LVN 1 stated the lab company would then come to the facility, review lab orders, and draw a resident's labs. LVN 1 stated upon drawing a resident's labs, the facility's lab company would provide a receipt for each resident seen indicating labs were drawn. LVN 1 stated she did not see a receipt for CBC and CMP labs nor results from labs being drawn for Resident 4. LVN 1 stated the risk of not carrying out physician orders for lab work could result in not knowing if the services were provided, a delay in nursing services, not following doctor's order and possible harm to a resident.During a review of the facility's policy and procedures (P&P), titled Laboratory Services, revised 1/1/2012, the P&P indicated, Upon receiving the order, the Licensed Nurse will do the following: Notify the laboratory of the laboratory orders.During a review of the facility's policy and procedures (P&P), titled Physician Orders, dated 12/28/2022, the P&P indicated, Lab orders will include the name of the desired test, the frequency, reason for the test and associated diagnosis.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of six sampled residents (Resident 2) Activities of Daily Living ([ADL] -routine task/activities such as bathing, dressing and toileting a person performs daily to care for themselves) was provided personal hygiene (the ability to maintain personal hygiene, including combing hair, shaving).This deficient practice of not maintaining standards of practice had the potential to compromise Resident 2's personal hygiene. During a review of Resident 2's admission Record ([Face Sheet] front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 2 was initially admitted to the facility on [DATE] and was readmitted on [DATE]. Resident 2's diagnoses dementia (a progressive state of decline in mental abilities), muscle weakness (a reduced ability to generate force in muscles, impacting strength function, and movement), and chronic obstructive pulmonary disease ([COPD] - a chronic lung disease causing difficulty in breathing). During a review of Resident 2's History and Physical (H&P), dated 10/22/2025, the H&P indicated, Resident 2 had cognitive impairment (problems with thinking abilities such as memory, concentration, decision-making, and problem solving). During a review of Resident 2's Minimum Data Set ([MDS] a resident assessment tool), dated 10/31/2025, the MDS indicated Resident 2's cognition (ability to learn, reason, remember, understand, and make decisions) was moderately impaired. The MDS indicated Resident 2 was partial/moderate dependent (helper does less than half the effort) on staff for personal hygiene, showering, and dressing. During a concurrent observation and interview on 1/7/2026 at 11:40 a.m., with Resident 2, in Resident 2's room, Resident 2 had a large amount of facial hair on chin and dirty fingernails that were untrimmed. Resident 2 stated she had not been shaved on her chin for a long time and did not want hair on her chin. Resident 2 stated she also would want her nails to be clean and trimmed. Resident 2 stated it was embarrassing to not have her face and nails not clean looking. During a concurrent observation and interview on 1/7/2025 at 12:00 p.m., with Certified Nursing Assistant (CNA) 2, Resident 2 had a large amount of facial hair on chin and dirty fingernails that were untrimmed. CNA 2 stated Resident 2's did not look groomed due to her having facial hair on her chin and dirty nails. CNA 2 stated Resident 2 needed assistance with personal hygiene. CNA 2 stated the role of the CNAs to provide personal hygiene care to the residents on shower days and as needed. CNA 2 stated not grooming Resident 2 could make her feel non-presentable. During a concurrent observation and interview on 1/7/2026 at 1:58 p.m., with Registered Nurse (RN) 1, Resident 2 had a large amount of facial hair on chin and dirty fingernails that were untrimmed. RN 1 stated Resident 2's had facial hair, and her nails were dirty and untrimmed. RN 1 stated it was important for Resident 2 to be groomed and have trimmed clean nails for her overall well-being. During a review of facility's policy and procedure (P&P) titled Grooming, dated 1/2012, the P&P indicated the facility will work with residents to improve their ability to groom, to promote independence, hygiene, comfort, self-esteem and dignity. The P&P indicated to assist with shaving and hair grooming. The P&P indicated nail care with nail brush to remove dirty particles under nail and keep nails short.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation interview and record review, the facility failed to: 1.Ensure a low air loss mattress (a mattress designed to prevent and treat pressure wounds) setting was correct for one of six sampled residents (Resident 3). This deficient practice had the potential to result in further skin breakdown.Findings:During a review of Resident 3's face sheet (front page of the chart that contains a summary of basic information about the resident), the face sheet indicated Resident 3 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Resident 3's diagnoses included a stage 4 pressure ulcer (full thickness tissue loss with exposed bone, tendon, or muscle), dysphagia (difficulty swallowing), type 2 diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and urinary tract infection (UTI- an infection in the bladder/urinary tract).During a review of Resident 3's history and physical (H&P) form, dated 10/1/2025, the H&P indicated Resident 3 had the capacity to understand and make decisions.During a review of Resident 3's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 10/15/2025, the MDS indicated Resident 3's cognitive (thinking) skills were cognitively intact. The MDS also indicated Resident 3 was dependent on staff with Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).During an observation, on 1/6/2025 at 10:13 a.m., Resident 3 was observed lying in bed on a low air loss mattress with weight settings at 150 lbs.During a record review, on 1/6/2025 at 1:57 p.m., of Resident 3's weight, Resident 3's weight indicated Resident 3 weighed 206 lbs.During a concurrent observation and interview, on 1/8/2026 at 1:46 p.m., with the Treatment Nurse 1 (TN 1), TN 1 observed and stated Resident 3's low air loss mattress settings were set to 150 lbs.During a concurrent interview and record review, on 1/8/2026 at 2:31 p.m., with TN 1, TN 1 stated all low air loss mattresses settings was based on a resident's weight. TN 1 stated the purpose of low air loss mattresses was to prevent further skin breakdown in residents with pressure ulcers. TN 1 stated that Resident 3 weighed 206 lbs. TN 1 stated Resident 3's low air loss mattress setting was incorrect. TN 1 stated the risk of setting a low air loss mattress on a wrong weight or setting could result in further skin breakdown.During a review of the facility's policy and procedures (P&P), titled Mattresses, dated 1/1/2012, the P&P indicated, The Facility will provide mattresses capable of meeting the following needs of residents: To provide pressure reduction to residents at risk for skin breakdown. To distribute body weight relieving areas of pressure.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to properly remove expired items and failed to organize stored items in the medication storage room. This failure had the potential to result in staff using expired items for specimen collection and a delay of care for residents while searching for necessary care items. During an observation on [DATE] at 12:33 p.m., in the medication storage room, the following was observed: One open bottle of baby oil in the far-right upper cabinet, Two containers of air freshener, a used face mask, one BD Safety Glide 1mL syringe, and multiple specimen bags were in drawer 1, labeled elastic bandage rolls. Two expired Aptima urine specimen collection kits dated [DATE], (6) 4 mL expired vacutainers, and (1) expired HOLOGIC Aptima 2cc urine specimen container dated [DATE], in the second drawer 2 to the left. During an interview on [DATE] at 12:50 p.m., with LVN2, in the medication storage room, LVN2 stated that baby oil is not medication and should not be in the medication storage room. LVN2 stated that expired items cannot be used and if they were to be accidentally used there could be a risk of incorrect results if used beyond the expiration date, and when items are not stored in an organized manner, it will take a longer time to provide care. During a review of the Medication Storage in the Facility Policy & Procedure (P&P), dated [DATE], the P&P indicated, medication and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. Medication storage areas are kept clean, well-lit, and free of clutter and extreme temperatures and humidity.		

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure one of six sampled residents (Resident 2) recommendations for laboratory services were not completed. This deficient practice of not following up with the Medication Regimen Review ([MRR] - a medication list that is reviewed to ensure safety and effectiveness, eliminate unnecessary drugs) recommendations had the potential to cause a delay in emergency medical care and treatment. During a review of Resident 2's admission Record ([Face Sheet] front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 2 was initially admitted to the facility on [DATE] and was readmitted on [DATE]. Resident 2's diagnoses dementia (a progressive state of decline in mental abilities), muscle weakness (a reduced ability to generate force in muscles, impacting strength function, and movement), and chronic obstructive pulmonary disease ([COPD] - a chronic lung disease causing difficulty in breathing). During a review of Resident 2's History and Physical (H&P), dated 10/22/2025, the H&P indicated, Resident 2 had cognitive impairment (problems with thinking abilities such as memory, concentration, decision-making, and problem solving). During a review of Resident 2's Minimum Data Set ([MDS] a resident assessment tool), dated 10/31/2025, the MDS indicated Resident 2's cognition (ability to learn, reason, remember, understand, and make decisions) was moderately impaired. The MDS indicated Resident 2 was partial/moderate dependent (helper does less than half the effort) on staff for personal hygiene, showering, and dressing. During a review of Resident 2's Medication Regimen Review (MRR) titled, Consultant Pharmacist's MRR, dated 12/27/2025, the MRR indicated please ensure to obtain CMP (standard blood test to check fluid/electrolyte balance), CBC (test to measure the numbers and size of the different cells in blood), and valproic level (to measure the effective range in the bloodstream during treatment). During a concurrent interview and record review on 1/8/2026 at 1:40 p.m., with Registered Nurse (RN) 1, the MRR titled, Consultant Pharmacist's MRR, dated 12/27/2025 was reviewed. The MRR indicated please ensure to obtain CMP, CBC, and valproic level. RN 1 stated there was no documentation and the recommendations were not acknowledged. RN 1 stated when the laboratory recommendations were in place; an order request should have been placed to the physician. RN 1 stated there was a recommendation it should take no more than three days to complete. RN 1 stated Resident 2's blood work was not drawn. RN 1 stated the staff had failed to carry out the recommendations. RN 1 stated this could have potentially affected Resident 2's medication regime and caused a delay in care. During a review of the facility's policy and procedures (P&P) titled, Consultant Pharmacist Reports, dated 12/2019, the P&P indicated MRR includes evaluation the resident's response to medication therapy to determine that the resident maintains the highest practicable level of functioning and preventing adverse consequences related to medication therapy. The P&P indicated recommendations are acted upon and documented by the facility staff.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055167	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2026
NAME OF PROVIDER OR SUPPLIER Vernon Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1037 W. Vernon Avenue Los Angeles, CA 90037	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility Licensed Nurse 1(LVN1) failed to perform hand hygiene (cleansing hands with soap or an alcohol-based rub), at the door of room [ROOM NUMBER], prior to touching medication cups during preparation for medication administration. This failure had the potential for cross contamination (process by which bacteria or other microorganisms are unintentionally transferred from one object or person to another, with harmful effect) and risk to exposure of residents to infectious organisms (germs). During an observation on 1/8/2026 at 7:47 a.m., at medication cart #1, LVN1 failed to perform hand hygiene before preparing medication cups for medication administration (the action of dispensing, giving, or applying something) . During an interview on 1/8/2026 at 7:50 a.m. with LVN1, LVN1 stated cross contamination (the process by which bacteria or other germs are transferred from one substance or object to another) could occur, or a serious illness could be spread to someone. During a review of the Preparation and General Guidelines IIA2: Medication Administration-General Guidelines Policy & Procedure (P&P), dated May 2022, the P&P indicated the person administering medications adheres to good hand hygiene, which includes washing hands thoroughly: before beginning a medication pass.		

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NAME OF PROVIDER OR SUPPLIER Vernon Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1037 W. Vernon Avenue Los Angeles, CA 90037	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. Based on observation, interview and record review, the facility failed to:1.Provide at least 80 square feet (sq. ft.- a unit of measurement) per resident for 31 out of 34 resident bedrooms. This deficient practice had the potential to result in inadequate nursing care and safety issues for the residents.Findings: During a facility tour, on 1/6/2025 at 8:34 a.m., rooms 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 14, 15, 16,17,18, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34 and 35 were observed and residents were able to move in and out of their rooms. It was observed that there was enough space for the residents' beds, bedside tables, and resident care equipment. During a review of the facility's waiver request for bedrooms to measure at least 80 sq. ft. per resident letter, dated 10/1/2025, the facility's waiver request submitted by the Administrator (Admin) for 31 out of 34 resident rooms was reviewed. The waiver request letter indicated the granting of the waiver will not adversely affect the residents' health and safety and in accordance with the special needs of the residents at the facility. The following rooms provided less than 80 sq. ft per resident:Room NumbersNumber of Residents Square Footage232221.633221.643223.253221.663222.673222.683223.393222.6103222.6113222.6123224.2143222 During an interview on 1/8/2025 at 2:01 p.m. with the Administrator (Admin), the Admin confirmed the facility had rooms less than the required 80 sq. ft. per resident. The Admin stated there had not been any complaints from residents about the amount of square footage in their rooms nor had it affected residents in an adverse effect regarding health and safety. The Admin stated staff were also still able to continue to render all residents' care and necessary services without any harm or safety issues due to the lack of necessary footage.The minimum sq. ft. for a three residents capacity bedroom is 240 sq. ft.		